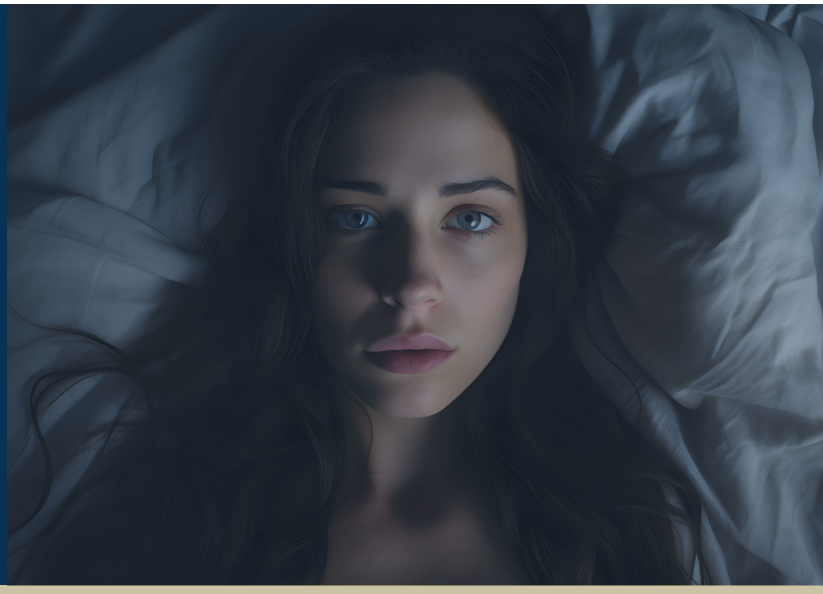
SUMMER 2024

LIFELINE

A PUBLICATION OF THE LIFE LEGAL DEFENSE FOUNDATION

Death Culture Arrogance: Those Who "Will Never Recover" Do in Fact Often Recover

by Alexandra Snyder



Jesse called us in a panic. A few days earlier, he found his fiancée, Tuesday, on the kitchen floor gasping for breath. One of Jesse's friends rushed Tuesday to the hospital, which was only five minutes away, while Jesse performed CPR on Tuesday in the back seat with the guidance of a 911 operator.

At the hospital, Jesse watched in desperation as the emergency room team attempted to resuscitate Tuesday. Finally—after what seemed like an eternity—her heart started beating again. By that time, Tuesday had been without oxygen for several minutes, causing severe swelling in her brain. She needed a ventilator to help her breathe and a feeding tube for nutrition and hydration.

Jesse made it clear to the hospital that he wanted to give Tuesday every possible opportunity to recover. This led to some tense discussions with Tuesday's medical team. Doctors pressured Jesse to withdraw Tuesday's ventilator, saying she would "never, EVER, breathe on her own again." They said Tuesday would always be a "vegetable." Jesse insisted that Tuesday continue to receive ventilator support as well as any other medical care she needed. After all, she had only been admitted to the hospital a week earlier.

Tuesday had experienced a similar, but less serious, asthma attack the year before. After she recovered, she executed a health care power of attorney to ensure that Jesse would be able to make medical decisions

CONTINUED ON PAGE 2

CONTINUED FROM PAGE 1

on her behalf in case she was left incapacitated by another episode.

Jesse informed Tuesday's doctors about the power of attorney, but as he challenged their recommendations, they challenged the validity of the document, ultimately refusing to acknowledge him as Tuesday's health care decision-maker. When the medical staff realized they couldn't convince Jesse to withdraw care, the hospital reached out to Tuesday's mother, who lived in another state. The hospital unilaterally authorized Tuesday's mother to make health care decisions on her daughter's behalf.

Shortly before Tuesday's mother arrived in California, Tuesday began taking breaths on her own. Within a few days, she only required minimal ventilator support. It would not be the last time doctors were wrong about her prognosis.

A study published in May 2024 found that a "substantial proportion" of patients with brain injuries who were deprived of life-sustaining care "may have survived an achieved at least partial independence."[1] The study, which was published in the *Journal of Neurotrauma*, notes that the decision to withdraw life-sustaining care is often made within 72 hours of a brain injury, even though "some patients could have recovered consciousness, self-expression, or even independence."

Yet how many brain-injured patients are killed prematurely because doctors convince their loved ones that they will never recover?

Researchers also discovered that critical care physicians, who usually do not monitor patients over the long term, may "overestimate the likelihood of a poor outcome." The patient's loved ones rely on clinicians to make decisions about continuing medical treatment.

According to the study, "poor neurologic prognosis conveyed by clinicians is among the most common reasons family choose WLST [withdrawal of life-sustaining care]."

As more families choose to withdraw care, critical care physicians see fewer patients exhibit signs of recovery, "resulting in WLST for subsequent patients."

This becomes a "self-fulfilling prophecy," which increases the likelihood of a poor outcome—including death as patients are deprived of essential care. Deaths caused by withdrawal of life-sustaining care are often reported as brain injury deaths—which affects research findings and influences clinical decision-making.

The findings of the study "provide evidence that some patients who die after WLST may have recovered independence months after injury."

Researchers thus recommend delaying decisions about withdrawing life-sustaining care to allow patients more time to potentially achieve recovery. This approach is grounded in several key considerations, including:

1. Uncertainty in prognosis. Early in a patient's critical brain injury, it is often difficult to accurately predict

the likelihood of recovery. Giving more time can lead to a clearer understanding of the patient's prognosis.

2. Potential for improvement. As the study found, some patients may show signs of improvement with extended care. Medical advancements and individualized care can lead to unexpected recoveries months after the initial brain injury.

3. Psychological and ethical considerations. Families and healthcare providers need time to process the situation and make informed, ethically sound decisions. Rushing this process can lead to regrets or feelings of guilt.

By postponing decisions about withdrawing life-sustaining care, physicians and families ensure that patients are given the best possible chance for recovery.

In Tuesday's case, when doctors told her mother about what they believed to be her poor prognosis, she was inclined to withdraw Tuesday's medical care. We filed a lawsuit seeking a court order to continue treatment, including ventilator support and nutrition and hydration. Over the course of litigation, we learned that Tuesday had spent much of her childhood in foster care because of an abusive home situation. We provided the court with documentation that Tuesday's mother was the last person who should be making health care decisions for her daughter.

Ultimately, Tuesday's power of attorney was validated and Jesse was able to make medical decisions in her—not the hospital's—best interests. The last time I heard from Jesse, Tuesday could feed herself and was starting to speak again. She had a long road ahead, but she was alive and recovering. If Jesse had relied on the doctors' prognosis—and if Life Legal attorneys had not intervened—Tuesday would be dead.

According to the *Journal of Neurotrauma* study, over 50% of severely brain injured patients regained "at least partial independence . . . by 6 months post-injury," although older and more severely injured patients took up to 12 months to achieve some degree of independence. Even patients who were dependent "nevertheless report normative quality of life."

> JESSE INFORMED TUESDAY'S DOCTORS ABOUT THE POWER OF ATTORNEY, BUT . . . THEY CHALLENGED THE VALIDITY OF THE DOCUMENT, ULTIMATELY REFUSING TO ACKNOWLEDGE HIM AS TUESDAY'S HEALTH CARE DECISION-MAKER.

Yet how many brain-injured patients are killed prematurely because doctors convince their loved ones that they will never recover?

Life Legal has handled many cases like Tuesday's on behalf of patients who were threatened with removal of life-sustaining care because doctors made a hasty determination that further treatment was useless. In nearly every case, hospitals seek to withdraw ventilator support and even nutrition and hydration within just a few days of patient's brain injury. And in many cases, we have seen patients with grim prognoses make amazing recoveries after we intervened to ensure continued life-sustaining care.

Tuesday's case, and others like it handled by Life Legal, illustrate the profound consequences of rushing to withdraw life-sustaining treatment. Decisions made in the early, uncertain stages of brain injury can have irreversible outcomes, depriving patients of the possibility of recovery. It is crucial for families and medical professionals to delay such decisions, allowing time for a more accurate prognosis and potential improvements in the patient's condition.

Tuesday's case powerfully underscores the importance of vigilance and persistence when confronted with dire medical predictions. By ensuring that decisions about withdrawing life-sustaining care are not made prematurely, we can provide patients with the best possible chance for a meaningful recovery. Jesse's unwavering commitment and the efforts of Life Legal made all the difference for Tuesday, illustrating the profound impact of legal advocacy in medical care.

You can read more about Jesse's story in this *Billboard Magazine* article: https://www.billboard.com/music/music-news/eagles-of-death-metal-tuesday-cross-out-of-coma-jessehughes-1235047593/

[1]https://pubmed.ncbi.nlm.nih.gov/38739032/#:~:text=Of%2056%20WLST%2D%20participants%20who,6%20months%2C%20post%2Dinjury.

Supreme Court Punts In Two Abortion Cases

by Sheila Green

The Supreme Court recently handed down decisions in two cases involving the federal government's attempt to force its pro-abortion agenda against pro-life states, hospitals and individuals.

Unfortunately, in neither decision did the Court actually reach the merits of the case but chose instead to decide on procedural grounds.

In *FDA v. Alliance for Hippocratic Medicine*, Justice Kavanaugh, writing for a unanimous Supreme Court, denied standing to plaintiff pro-life doctors and medical organizations who sued the FDA for violating their conscience rights, first by approving the abortion-inducing drug mifepristone in 2000 and, later by removing important safeguards surrounding its use. In 2016 and 2021, the FDA abolished safeguards such as requiring that the first pill of the abortion drug regimen be taken in front of a doctor—a requirement meant in part to ensure, for safety reasons, that the woman did not wait until later in pregnancy to take the drug. It also allowed the administration of the abortion drug later into pregnancy. Despite the additional risk posed with these changes, the FDA also removed the requirement that all adverse effects of mifepristone be reported, instead requiring reporting only in cases where mifepristone causes death.

The pro-life medical groups challenged both the original politically-driven approval process and the subsequent changes. Their experience as OB-GYNs and emergency room doctors showed that the abortion pills were dangerous and that removal of safeguards further increased the number of women going to ERs with complications. This increase in turn resulted in pro-life doctors being required to perform procedures to "finish" incomplete abortions, in violation of their conscience rights. Their challenge sought to either rescind the FDA approval of the drug or, failing that, to require the FDA to restore the common-sense restrictions governing this dangerous drug.

But the Court ruled that the doctors lacked standing to challenge the FDA's actions at all. The Court reasoned first that the doctors and medical associations "are unregulated parties who seek to challenge FDA's regulation *of others*" since they themselves do not prescribe mifepristone, nor does the FDA require them to do so. Second, the Court found that federal conscience laws "definitively protect doctors from being required to perform abortions or to provide other treatment that violates their consciences." The Court affirmed the doctors' right of conscience to refuse to perform an abortion or to provide other abortion-related treatment in violation of the doctor's conscience, "even in a so-called healthcare desert, where other doctors are not readily available."

This resolution, however, failed to fully address an argument Life Legal presented in our amicus brief, namely that in those "healthcare deserts," doctors will have to choose between providing care in violation of their consciences, or allowing a woman's health condition to deteriorate, perhaps resulting in death, also in violation of their conscience as well as their professional oaths. The Court noted that "doctors need not follow a time-intensive procedure to invoke federal conscience protections" but could "simply refuse," and that "hospitals and doctors typically try to plan ahead for how to deal with a doctor's absence due to conscience objections." However, the scenarios presented by the plaintiff doctors took place in emergency rooms, not always having the option of "planning ahead." Even if ER doctors were not actually forced to end the life of a child, they were regularly called on to provide care that would complete the abortion, and thus be part of the abortion process.

The Court directed the physicians to "present their concerns and objections to the President and FDA in the regulatory process, or to Congress and the President in the

legislative process." But the point of guarantees for conscience and religious freedom is to provide a zone of protection against infringements by the politics of the moment. And while the decision contained a robust defense of the right of doctors to refuse to participate in abortion, that defense itself was based on protections provided by statute, rather than being rooted in the Constitution. Congress and the President can chip away at or remove those protections, and this President would undoubtedly be willing to do just that in his single-minded quest to expand abortion.[1]

That quest was the impetus for the second abortion case on the Supreme Court's docket this past term, *Moyle v. United States/Idaho v. United States. Moyle* concerns Idaho's 2022 Defense of Life Act, which prohibits all abortions except those necessary to protect the life of the mother, or in cases of rape or incest. Shortly after the law's passage and the Court's decision in *Dobbs* overturning *Roe*, the Biden Administration sued Idaho, alleging that the federal Emergency Medical Treatment and Labor Act (EMTALA) pre-empted the state law and required that hospitals receiving Medicare funds must provide medical care, including abortion, in the case of an emergency medical condition, including conditions affecting a woman's health. The parties therefore identified a gap between what EMTALA requires and what the Defense of Life Act would prohibit—the performance of abortions in situations that fall short of threatening the life of the mother.

In January of this year, the Court granted a stay of the District Court's preliminary injunction against the enforcement of Idaho's law.

That meant that the law was in effect pending the Supreme Court's deliberations, and almost all abortions in Idaho were disallowed. When the Court granted the stay, it also granted a writ of certiorari to hear the case on the merits.

But although the case fully briefed and the Court heard oral argument, the Court did not decide the issue. Instead, with the vote of six of the

Justices, the Court dismissed the writs of certiorari as "improvidently granted." Five of those justices believe, for different reasons, that the case should proceed through the lower courts before being decided by the Supreme Court on the merits. But the same six justices also voted to lift the stay, meaning that the district court's order enjoining enforcement of the Defense of Life Act is back in force.

But how much force is far from clear.

The Court's unsigned order was accompanied by four opinions. Justice Kagan, joined by Justices Sotomayor and Jackson, wrote that Idaho's argument was not likely to succeed on the merits because they believe that EMTALA preempts state laws that prohibit abortions for the protection of maternal health. Justice Jackson, in a lone dissent, argued that, rather than punting, the Court should have decided the merits immediately and pre-empted the Idaho law.

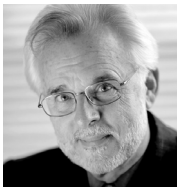
Justices Barrett, in a concurrence joined by Chief Justice Roberts and Justice Kavanaugh, wrote that, because the State and the federal government changed their positions on the meaning of their respective laws from what was originally presented to the Court, the cases "are no longer appropriate for early resolution." The changes in the parties' views of their laws had "rendered the scope of the dispute unclear." The three Justices believed that the changes were significant enough to require the suit to proceed in the lower courts before the Supreme Court weighs in on the merits.

There were a few silver linings in Barrett's opinion, starting with the concluding sentence where, she stated that in light of the changed positions, "Idaho's ability to enforce its law remains almost entirely intact." She also reiterated that the federal government itself agreed that federal conscience provisions for hospitals and individual physicians apply against EMTALA's requirements.

Barrett's concurrence also pointed out the Solicitor General's assertion that, according to accepted standards of medical practice, *abortion is never necessary to stabilize a mental*

CONTINUED ON PAGE 7

Hospice and Palliative Nurses Association Plans to Surrender to Assisted-Suicide Agenda



by Wesley J. Smith

When Dame Cicely Saunders created the modern hospice movement, she adamantly rejected assisted suicide as an acceptable hospice activity. Indeed, when I interviewed Saunders for the original edition of my book *Culture of Death*, she stated unequivocally that assisted suicide "rejects the equal dignity of my patients."

That is why she designed hospice to engage in active suicide prevention when patients expressed suicidal desires as one of its most important services alongside pain control, social services, chaplaincy, and the like. In other words, as conceived by Saunders, hospices would be assisted-suicide-free zones.

Saunders would be spinning in her grave—she died in the St. Christopher's Hospice, which she founded—if she read the proposed policy around assisted suicide that has been published by the Hospice and Palliative Nurses Association (HPNA). It is both abject and a betrayal of Saunders's humanitarian vision for the care of dying people. And the statement contains not a hint of the many problems and abuses that have been associated with "medical aid in dying" (MAID), reasons why the European Court of Human Rights recently ruled that access to assisted suicide is not a human right.

The policy urges nurses to participate in assisted suicide absent a moral objection.

First, the proposed policy position embraces the word-engineering tactic of calling assisted suicide MAID. I have repeatedly criticized this euphemistic deflection and won't repeat those thoughts here.

Then, the statement calls participation in suicide a form of palliative care. From the proposed "HPNA Position Statement: Medical Aid in Dying (MAiD):"

> HPNA acknowledges that some patients with terminal illnesses may seek medical aid in dying (MAiD) as an end-of-life care option where legally available.

Although suffering is not a requirement in order to qualify for MAiD in the United States, some patients may utilize this option to relieve their suffering, which is consistent with the ethical principles of palliative nursing care. Suffering at the end of life may be caused by loss of control; death anxiety; feeling like a burden; and refractory physical, social, emotional, spiritual, and existential symptoms. MAiD is consistent with the fundamental ethical principles of patient autonomy and beneficence.

It is actually the opposite. As Dame Cicely knew so well, the proper

compassionate approach to suicidal ideation—whether in terminally ill people or otherwise—*is suicide prevention*, not participation and facilitation by medical professionals, of all people. Indeed, when I trained as a hospice volunteer in the 1990s, I was strictly instructed to alert the multidisciplinary team if a patient ever indicated a desire for suicide or immediate death.

Here's the abject part:

> HPNA adopts a stance of engaged neutrality regarding whether MAiD should be legally permitted or prohibited.

What in the hell does "engaged neutrality" even mean? But they really aren't fooling anybody. The long statement is almost all pro, pro, pro. Even its suggested "resources" for further information are one-sided.

The policy urges nurses to participate in assisted suicide absent a moral objection. The only good news here is that the statement respects medical conscience and the right of nonparticipation. (One would hope *all* palliation and hospice nurses would refuse to be complicit in any patient's suicide!):

> Nursing care for patients considering MAiD (and their families) is crucial to ensure that patients and families are not overtly or inadvertently disenfranchised or stigmatized as they proceed with MAiD and that they experience a safe and comfortable death, free from complications.

> "Safe" death "free from complications?" Good grief.

Once lethal injection is allowed legally, and eligibility expands beyond the terminally ill—as will eventually happen if the death agenda keeps marching forward—would the HPNA still suggest that nurses do the deed? Reading this proposed statement, I think it would.

[Wesley J. Smith (@forcedexit) is an author and a senior fellow at the Discovery Institute's Center on Human Exceptionalism and a consultant to the Patients Rights Council. This article was originally published by the National Review Online. (https://www.nationalreview.com/corner/hospice-and-palliative-nurses-association-plans-to-surrender-to-assisted-suicide-agenda/) June 24, 2024, and is here reproduced by kind permission of the author.]

CONTINUED FROM PAGE 5

health condition and that therefore EMTALA would only require abortions to address serious physical conditions. This is important because *Roe v. Wade* and *Doe v. Bolton* had been interpreted to allow abortions throughout pregnancy even for simple psychological reasons.

However, it is not clear how authoritative the Solicitor General's position is, since, as Alito's dissent noted, "prominent medical associations . . . endorse abortion for mental-health reasons as an accepted standard of practice."

Justice Alito, joined by Justices Thomas and Gorsuch, dissented and would have decided the case on the merits in favor of the State. They asserted that the clear language of EMTALA does not require doctors to perform abortions because the statute requires the protection of the health of the woman *and of her unborn child*. Indeed, EMTALA was amended in 1989 to specifically mandate consideration of the health "of the unborn child" in making decisions about treatment and transfer. With refreshing moral clarity, Justice Alito noted, "It goes without saying that aborting an 'unborn child' does not protect it from jeopardy."

While both Supreme Court decisions were disappointing in their own ways, neither represents a final resolution of the issue at hand. The fight against the FDA's approval of mifepristone awaits another plaintiff who, guided by the Court's opinion, would be able to establish standing and bring the Court to a substantive decision on the FDA's approval of this dangerous abortion drug.

As to EMTALA, Life Legal is hopeful, first, that a new administration will withdraw the current administration's broad, counter-textual interpretation of a statute specifically passed to protect the life and health of women *and* their unborn children. Failing that, if the issue comes before the Court again, we are optimistic that the Justices will reject the federal government's overreach and decide in favor of the plain language of the statute in its protection of the life of every threatened human being.

---

[1]Protecting Access to Reproductive Healthcare Services, Exec. Order No. 14076, 87 Fed. Reg. 42053 (2022).

LIFE LEGAL DEFENSE FOUNDATION

Editor — Alexandra Snyder
Production — John O'Rourke
Design — Kelly Connelly Design

LLDF.org/donate

ECFA ACCREDITED

Platinum Transparency 2023 Candid.

★★★★ CHARITY NAVIGATOR Four Star Charity

Life Legal Defense Foundation
P.O. Box 2105
Napa, California 94558

ADDRESS SERVICES REQUESTED

NONPROFIT ORG
US POSTAGE
PAID
BRAINERD, MN
PERMIT NO. 472

LIFE LEGAL

Family Dinner

You're invited

Please join us for a Life Legal family dinner to celebrate our 35th anniversary at a private winery in Napa on September 21.

Meet Helen Alvare and Mary FioRito, and Life Legal clients!

For more information or to RSVP call Life Legal at: (707) 224-6675

Tickets are $150 per person. Space is limited.

SEPTEMBER 21, 2024
4:00 PM
NAPA | CALIFORNIA

CELEBRATING 35 YEARS OF LIFE TOGETHER